STATEMENT OF DEFICIENCIES (X1) PI		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY	
AND PLAN OF CORRECTION		IDENTIFICATION NUMBER:	A. BUILDING	01	COMPLETED	
	155735		B. WING O5.		05/16/2011	
		<u> </u>		ADDRESS, CITY, STATE, ZIP CODE	<u> </u>	
NAME OF F	PROVIDER OR SUPPLIER	R.		ORTH RILEY HIGHWAY		
	RD PLACE HEALTH	CAMPUS		YVILLE, IN46176		
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL		ID	PROVIDER'S PLAN OF CORRECTION	(X5)	
PREFIX			PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA		
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)	TAG	DEFICIENCY)	DATE	
K0000						
	A Life Safety Code Recertification and		K0000	Ashford Place Health Campi		
	State Licensure S	Survey was conducted by		submits this plan of correction		
	the Indiana State	Department of Health in		response to the allegation of noncompliance cited during		
		42 CFR 483.70(a).		Life Safety Code Recertification		
		()-		and State Licensure Survey	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	
	Survey Date: 05	5/16/11		conducted on May 16,		
	Survey Date. 03	7 10/ 11		2011 Please accept this plan		
	Facility N1	. 004269		correction as the provider's I	etter	
	Facility Number: 004268			of credible allegation of	_	
	Provider Number			compliance effective June 19 2011. The Provider respectful	•	
	AIM Number: 2	00504460		requests a desk review with	"y	
				paper compliance to be		
	Surveyor: Phillip Komsiski, Life Safety Code Specialist			considered in establishing th	at	
				the provider is in substantial		
				compliance.		
	At this Life Safety Code survey, Ashford					
		npus was found not in				
		Requirements for				
	1 1	•				
	Participation in Medicare/Medicaid, 42 CFR Subpart 483.70(a), Life Safety from Fire, and the 2000 edition of the National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 18, New					
		upancies and 410 IAC				
	16.2.					
	This one story fa	cility was determined to				
	be of Type V (11	1) construction and was				
	fully sprinklered	. The facility has a fire				
		th smoke detection in the				
	1	open to the corridors and				
	_	oing rooms. The facility				
	_	68 and had a census of				
	mas a capacity of	oo and nad a census of				
LABORATOR	Y DIRECTOR'S OR PROV	/IDER/SUPPLIER REPRESENTATIVE'S SIC	SNATURE	TITLE	(X6) DATE	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

(X6) DATE

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

H2GZ21

Facility ID:

004268

STATEMENT OF DEFICIENCIES		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION (X		(X3) DATE SURVEY		
AND PLAN OF CORRECTION		IDENTIFICATION NUMBER:	A. BUILDING 01		COMPLETED		
		155735	B. WING			05/16/2011	
			1	STREET AI	DDRESS, CITY, STATE, ZIP CODE		
NAME OF I	PROVIDER OR SUPPLIER				ORTH RILEY HIGHWAY		
ASHFORD PLACE HEALTH CAMPUS					VILLE, IN46176		
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIES			ID PROVIDER'S PLAN OF CORRECTION			(X5)
PREFIX	`	CY MUST BE PERCEDED BY FULL	PI	PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE		ΓE	COMPLETION
TAG	REGULATORY OR	REGULATORY OR LSC IDENTIFYING INFORMATION) TAG ORGOGIAL EXCHANGE IN THE ALTHOR DEFICIENCY)					DATE
	52 at the time of	this survey.					
	Safety Code Special 05/19/11. The facility was	Robert Booher, REHS, Life dist-Medical Surveyor on found not in compliance entioned regulatory evidenced by the					
K0017 SS=E	Corridor walls form a barrier to limit the transfer of smoke. Such walls are permitted to terminate at the ceiling where the ceiling is constructed to limit the transfer of smoke. No fire resistance rating is required for the corridor walls. 18.3.6.1, 18.3.6.2, 18.3.6.5 Based on observation and interview, the facility failed to ensure 1 of 1 open use areas were separated from the corridor or met an Exception. LSC 18.3.6.1, Exception # 1 Spaces shall be permitted to be unlimited in area and open to the corridor, provided the following criteria are met: (a) The spaces are not used for patient sleeping rooms, treatment rooms, or hazardous areas. (b) The corridors onto which the spaces open in the same smoke compartment are protected by an electrically supervised automatic smoke detection system in accordance with 18.3.4, or the smoke compartment in which the space is located is protected throughout by quick-response sprinklers.		K00	017	1. What corrective action(s) be accomplished for those residents found to have been affected by the deficient practice. After review, there we no residents found to be affe by alleged deficiency. 2. How other residents have the pote to be affected by the same deficient practice will be indentified and what corrective action(s) will be taken. There no residents with the potentiable affected by the alleged deficiency. 3. What measures will be put into play what systemic changes will be made to ensure that the deficiency ractice does not recur. The forotection vendor was contacted following the inspection. A significant procedure of the second of the seco	vere cted v ential ve were al to ce or e cient ire cted	05/25/2011

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: H2GZ21 Facility ID:

004268 If continuation sheet

Page 2 of 5

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED 01 A. BUILDING 155735 05/16/2011 B. WING STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 2200 NORTH RILEY HIGHWAY ASHFORD PLACE HEALTH CAMPUS SHELBYVILLE, IN46176 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES (X5) PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) PREFIX (EACH DEFICIENCY MUST BE PERCEDED BY FULL PREFIX COMPLETION TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG DATE (c) The open space is protected by an detector was installed in the business office above the glass electrically supervised automatic smoke sliding window on 5-25-11. See detection system in accordance with exhibit A4. How corrective 18.3.4, or the entire space is arranged and action(s) will be monitored to ensure the deficient practice will located to allow direct supervision by the not recur, i.e., what quality facility staff from a nurses' station or assurance program will be put similar space. (d) The space does not into place. The fire protection obstruct access to required exits. This vendor will do a bi-annual smoke deficient practice could affect 3 residents detector inspection. These inspections/tests will be submitted observed lounging by the front Reception to our Safety/QA report by plant office as well as any visitor or staff using operations, as completed for the front entrance to evacuate the facility. monitoring purposes. Findings include: Based on observation on 05/16/11 at 12:44 p.m. with the Maintenance Supervisor, the sliding glass doors installed at the front Reception office were not self closing and were open to the front entrance corridor. Exception # 1, requirement (c) of the Life Safety Code, Chapter 18.3.6.1 was not met as follows: the open area was not protected by an automatic smoke detection system or arranged to allow direct supervision by facility staff from a continuously staffed area such as a nurses' station. Based on interview on 05/16/11 at 12:47 p.m. with the Maintenance Supervisor, it was acknowledged the front Reception office was open to the entry corridor without supervision from the nurse's station and was not protected by automatic smoke

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A PUBLISHED OT		(X3) DATE SURVEY COMPLETED	
		155735	A. BUII			05/16/2	
NAME OF PROVIDER OR SUPPLIER ASHFORD PLACE HEALTH CAMPUS			B. WING GS/16/2511 STREET ADDRESS, CITY, STATE, ZIP CODE 2200 NORTH RILEY HIGHWAY SHELBYVILLE, IN46176				
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIES		1	ID			(X5)
PREFIX	(EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE		COMPLETION
TAG			TAG		DEFICIENCY)		DATE
	detection.			Ĭ			
K0067	3.1-19(b) Heating, ventilating	g, and air conditioning					
SS=F	are installed in acc manufacturer's spo 18.5.2.2, NFPA 90 Based on record	provisions of section 9.2 and ecordance with the pecifications. 9.2, 18.5.2.1, 0A I review and interview, the		0067	What corrective action(s) will be accomplished for those		06/15/2011
	in the ventilating inspected and promaintenance at leaccordance with requires air conditional ventilating ductwequipment shall leaction of Air Conditional Systems. NFPA maintenance requipment shall be fully close; the laction checked, and mollubricated as necessitions and staff.	east every four years in NFPA 90A. LSC 9.2.1 itioning, heating, work (HVAC) and related be in accordance with dard for the Installation ing and Ventilating 90A, 1999 Edition, 3.4.7, uires at least every 4 ks shall be removed; all operated to verify they atch, if provided, shall be ving parts shall be essary. This deficient ll residents including			residents found to have beer affected by the deficient practice. After review, there we no residents found to be affe by alleged deficiency. 2. How other residents having the potential to be affected by the same deficient practice will be indentified and what corrective action(s) will be taken. All residents have the potential that affected by the same alleged deficiency. 3 What measures be put into place or what system changes will be made to ensith at the deficient practice does not recur. Plant operations with inspect and provide necessal maintenance to dampers in the ventilating ductwork. Each damper will be logged on the Fire/Smoke Damper Mainten Record form. See exhibit B4 How corrective action(s) will monitored to ensure the deficient practice will not recur, i.e., who quality assurance program we put into place. Plant operatio will provide necessary inspective.	vere cted v e e e ve to be l s will temic ure es ll ry he e cient hat vill be ns	

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

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l	OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155735	A. BUILDIN B. WING		01	COMPL 05/16/2	ETED
NAME OF PROVIDER OR SUPPLIER ASHFORD PLACE HEALTH CAMPUS			STREET ADDRESS, CITY, STATE, ZIP CODE 2200 NORTH RILEY HIGHWAY SHELBYVILLE, IN46176				
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	II PRE TA	FIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ΓE	(X5) COMPLETION DATE
	Maintenance Sup was not available had ever been ins interview on 05/ the Maintenance acknowledged the any documentation	pervisor, documentation to indicate the dampers spected. Based on an 16/11 at 2:47 p.m. with Supervisor, it was the facility does not have on to verify the forty the forty that a four			and maintenance of dampers every four (4) years as requi Inspections will be submitted Safety/QA report as complet monitoring purposes.	red.	